

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Request to Amend Protected Health Information Approval Letter

Date: _____

To: _____

Re: Approval of Request to Amend Protected Health Information (PHI)

Dear _____:

Your request to amend your PHI (see copy of the request form), has been approved and we are in the process of notifying the individuals and/or organizations that you have identified.

In addition, we have identified the following individuals and/or organizations that received your PHI. If you would like us to notify the individuals and organizations listed below, please sign, date, and return this statement and we will continue with the notification process. Also, if there are any individual(s) or organization(s) that you think need to be notified that were not listed on your request, please add below.

Name: _____ Address: _____ Phone: ()	Name: _____ Address: _____ Phone: ()
Name: _____ Address: _____ Phone: ()	Name: _____ Address: _____ Phone: ()

If you consent to DMH notifying the above list of individuals and organizations, please sign and date below and return to me.

Your signature or Personal Representative's signature

Date

☐ DMH could not identify any individual and/or organization requiring notification.

Sincerely,

Signature: _____
Print Name: _____
Title: _____
Address: _____
Telephone: _____